STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED

SPECIAL COMMISSION MEETING
Tuesday, May 11, 2004
10:00am - 3:30 pm
MDCH Public Health Building #19
North Complex Baker-Olin West (BOW)
3423 N. Martin Luther King Blvd.
Manty Conference Room 1B & 1C
Lansing, Michigan 48906-2934

MEMBERS PRESENT:

RENEE TURNER-BAILEY (Chairperson)
NORMA HAGENOW (Vice Chairperson)
PETER AJLUNI, D.O.
BRADLEY CORY
JAMES K. DELANEY
DOROTHY DEREMO
EDWARD G. GOLDMAN
JAMES MAITLAND
MICHAEL SANDLER, M.D.
MICHAEL YOUNG, M.D.
ROGER G. ANDRZEJEWSKI

DEPARTMENT OF ATTORNEY GENERAL STAFF PRESENT

RON STYKA

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH STAFF PRESENT

JAN CHRISTENSEN
WILLIAM J. HART, JR.
LARRY HORVATH
BRENDA ROGERS

GENERAL PUBLIC ATTENDANCE

There were approximately 95 people in attendance

CHAIRPERSON RENEE TURNER-BAILEY: Good morning. Apparently our mikes are working, but we have to share them. It's 10:05, and I'm calling the May 11th meeting of the Certificate of Need Commission to order. I would like to welcome everyone to the second regularly scheduled meeting of the CON Commission for 2004. And our first order of business is the introduction of Commissioners and Staff because we do have one new Commissioner member. We're limited in microphones today. There's one on this side and one that side, so pass it along when you're done speaking. We're microphone challenged.

COMMISSIONER MIKE SANDLER: Mike Sandler, and I'm a diagnostic radiologist with the Henry Ford Systems, and I represent the M.D's on the Commission.

COMMISSIONER ROGER ANDRZEJEWSKI: My name is Roger Andrzejewski and I'm a vice president with Lacks Enterprises in Grand Rapids, Michigan. I'm here to represent the self-insurers. I look forward to working

with the CON Commission in the future.

CHAIRPERSON RENEE TURNER-BAILEY. Good morning, I'm Renee Turner-Bailey and I'm serving as Chair of the Commission, and I'm an employee of the Ford Motor Company.

COMMISSIONER NORMA HAGENOW: I'm Norma Hagenow. I've been a nurse for 40 years, so I always think I'm really representing nursing underneath it all, but my present role is president and CEO of Genesys Health System, and my slot on here is an expert relating to hospital administration.

COMMISSIONER JAMES MAITLAND: I'm Jim Maitland, Traverse City, Michigan, and I've been on the Commission for ten years. I'm just representing citizens of the state of Michigan on this.

COMMISSIONER JAMES DELANEY: Jim Delaney. I'm the vice president with the Benefits Design Administration and consulting firm.

COMMISSIONER MICHAEL YOUNG: My name is Michael Young and I've been a primary care physician for the last 20 years, and this is my first year on the Commission. I'm happy to be here.

COMMISSIONER EDWARD GOLDMAN: Ed Goldman, and I'm Deputy General Consult with the University of Michigan. I've just been reappointed to the Commission for a second term. My reappointment indicated that I'm representing the interest of hospitals, so,

COMMISSIONER DOROTHY DEREMO: I'm Dottie Deremo, and I'm president and CEO of Hospice of Michigan, which provides 25 to 30 percent of all the end of life care in the state, through 24 sites throughout the state, and I am also a nurse and I'm representing nursing.

COMMISSIONER BRADLEY CORY: My name is Brad Cory and I represent nursing homes. I recently retired as an administrator. I live in Marquette. I'm from the U.P., and yes, it is still in the United States.

CHAIRPERSON TURNER-BAILEY: Thank you. Next we would like to take a quick review of the agenda. As you can see we have a full agenda today; 17 items. At this time I would ask if there are any additions or corrections or changes suggested to the agenda? Hearing not, I'll accept a motion to accept the agenda as written.

COMMISSIONER MAITLAND: Maitland moves for it.

CHAIRPERSON TURNER-BAILEY: Commissioner Maitland moves for it, Commissioner Young, all in favor, signify by saying aye.

COMMISSION: Aye.

CHAIRPERSON TURNER-BAILEY: Opposed. Motion carries. Declaration of conflict of interest at this point.

COMMISSIONER SANDLER: I see that community health is on the agenda. As I stated previously I do know Dr. Joe from the Medical Society. Both of us are on the Board of Directors of the Michigan Medical Society, and his wife was a formal radiology resident of mines at Henry Ford. I don't feel as though one of them can be an actual conflict, and I'm sure that relationship wouldn't impact any voting that could take place, but I think everyone should know it.

RON STYKA: Just a couple of points. First, I need to clarify because I think in a previous discussion that I had with one of the Commissioners there was some misunderstanding. As I read and interpret your bylaws, when a Commissioner declares even a potential or an appearance of a conflict, at that point the other Commissioners, if they feel that it is something that requires further discussion, they should speak up. It's not required for the Commissioner to say I am in a conflict, but if they indicate that there is an appearance they should speak up. In failure to do so, would mean that the Commission is, in fact, agreeing that the conflict is not significant and not

of the nature that would prevent the person from voting. If you have any concerns that may be significant or needs further discussion, then you should speak up and the Commission should have a discussion about it. In your bylaws it says whether or not it would be a situation where someone on the Commission should rescue himself. The other thing that I wanted to mention is just a point of information. There was a request made by you, through your Chairperson, to the State Ethics Board for an advisory opinion regarding conflict of interest questions. That specifically arose with regard to standards proposed that are not currently on your agenda, dealing with moving some hospital beds out of Detroit to the western suburbs, for a lack of a better term, and so far that advisory board has had one hearing with regard to it, and determined that with regard to that specific item, Dr. Sandler was not in a conflict. They have not yet decided with regard to Commissioner Hagenow because she had to leave the meeting due to pressing business with her own employment. They will be taking it up with her at the next meeting at the beginning of June. At that time they will be making a determination with regard to the second question. I think in general we'll wait to see what their advice is, in general, in terms of how you should be looking at the conflict question and it may be helpful to you in. It may even change how you do things. We'll just have to wait and see.

CHAIRPERSON TURNER-BAILEY: Thank you. Was there any discussion, Commissioner Deremo?

COMMISSIONER DEREMO: None from me.

COMMISSIONER AIJUNI: In regards to his first point, rather than omitting any objection, I would like to come out in the affirmative and support Dr. Sandler's right to discuss and vote on this issue. I accept his explanation and I do not believe he's conflicted.

CHAIRPERSON TURNER-BAILEY: Would you like to make a comment, Mr. Styka.

RON STYKA: In case we lost track, but we're going back not to the agenda item that involves community health.

COMMISSIONER DEREMA: I have two potential conflicts of interest. In terms of the Magnetic Resonance Imaging, I understand that Oakland Health System is going to be proposing an amendment that may be an advantage for Oakland Health System, and I'm a member of the Oakland Health System board, so I will probably need to rescue myself from that amendment. I don't know how that affects the overall item, so I would appreciate your advice on that. The second potential is that I do know Dr. Lonnie Joe. Professionally I know him, but personally I don't know him, but I have interacted with him. I do not believe that that in any way would impact my objectivity.

CHAIRPERSON TURNER-BAILEY: Thank you. There was a discussion on the point relative to Dr. Sandler's declaration. Are there any further discussion?

COMMISSIONER MAITLAND: This is Commissioner Maitland, and it's just a matter of timing. Are you saying that if we felt there was, and I don't at this point, if we felt there was a conflict that we have to do it now or can we do it prior to discussion?

RON STYKA: You have a choice. You can do it now or you can do it at the time the agenda item arises. The bylaws give you that opportunity either way.

CHAIRPERSON TURNER-BAILEY: I need a point of clarification myself. Now, Dr. Ajluni made a comment in the affirmative point supporting Dr. Sandler's discussion of his potential conflict. Do we need to take action on that?

RON STYKA: If you wanted to make it a motion, yes, but he didn't phrase it as a motion.

CHAIRPERSON TURNER-BAILEY: But if we don't take action, then it amounts to the same.

RON STYKA: Obviously the matter can come again at the time the item arises on the agenda. Otherwise, yes, you're correct.

CHAIRPERSON TURNER-BAILEY: Thank you. We'll just go at such time. Commissioner Deremo had a question.

RON STYKA: Yes, she had a question as to whether or not her rescuing herself would affect that would have. She can discuss, she can be a part of it, she will not be able to vote. As long as we have a quorum and you get six votes on the item, that does not affect the Commission's ability to continue with its work.

CHAIRPERSON TURNER-BAILEY: Great. I think we should accept what she has declared and go on. Thank you. We'll take a moment to review the minutes of the March 9th meeting, for those of you who haven't had a chance to look at those yet. Are there any additions, corrections, or changes to the minutes? Moved by Commissioner Delaney, supported by Commissioner Goldman to accept the minutes as written. All of those in favor signify by saying aye.

COMMISSION: Aye.

CHAIRPERSON TURNER-BAILEY: Opposed? None. Magnetic Resonance Imaging, Brenda.

BRENDA ROGERS: I'm Brenda Rogers. In your packet you have the MRI language that was discussed at your last meeting where you took proposed action on. Since that time we held a public hearing and the department had a couple of amendments to offer on the language, and you should have that in your packet. The first amendment, and I'm not going to read through all of the sections effected, but the amendment that we were initially changing and where we need some clarification on services/ units. After the public hearing and some various testimony on that, the department has decided to leave that language alone. That's the first amendment and that is affected throughout various sections of the document. The second amendment is in relation to the new language regarding the conversion and the miles. Originally the proposal was 25 miles, and you, through not only public comment, but just further review from the department, we found that procedurally we really wanted to stay with a radius, it's easier to track, et cetera. What we've done to address some of the concerns regarding that, because there some opposition not using radius, but that radius is consistent throughout a lot of our standards. What we did was reduce, we're proposing to reduce it from a 25 mile down to a 15 mile radius, that would still allow for the alterations for some of these various hospitals. We took that into consideration. Those are the two main amendments that we have, and all of the rest of the language is the same that was presented at the last Commission meeting.

CHAIRPERSON TURNER-BAILEY: Any questions? Commissioner Sandler.

COMMISSIONER SANDLER: Are we discussing the motion?

CHAIRPERSON TURNER-BAILEY: Well, I have to take public comments. Are there any questions of Brenda Rogers on the amendment or anything else?

COMMISSIONER GOLDMAN: Brenda, if we change from the 25 mile driving distance to the 15 mile radius, what does that do to the provincial number of units? I'm just looking at the language where you talked about seven additional fixed MRI's in the state; did that number change?

BRENDA ROGERS: It changes by about four.

COMMISSIONER DEREMO: Increasing or decreasing?

BRENDA ROGERS: Increasing, yes.

COMMISSIONER CHRISTENSEN: From eight to twelve.

CHAIRPERSON TURNER-BAILEY: Any other questions? Amy Barkholz:

AMY BARKHOLZ: Can you hear me? Hi, I'm Amy Barkholz and I'm senior director of Advocacy for the Michigan Health and Hospital Association. What I wanted to tell you all today is to thank you really for taking up this issue. The proposed MRI language really addresses a problem that many of our smaller enrolled hospitals raised. They are doing quite a large number of procedures through their mobile route, but they still weren't quite there yet, in terms of meeting 6,000 bodies because they were with their mobile routes only able to service two to three days a week. This language is still narrow and targeted, and it addresses hospitals that are the only provider in their county. None of that changes. I just wanted to quickly address the point that during the raise, the change in the mileage, and offer some explanation. We're very supportive of it. It was not our idea. I think after the public hearing there were some discussions that came out. I learned a little bit more about how the department calculates distance. I had always thought that the distance, if you're 25 miles from the next hospital, it's calculated by how many miles it took you to drive from one hospital to another, but that is not the case, because the departments started calculating distance long before we could all get on Mapquest, and find out exactly how far it was from one hospital to another and document that in some way. So, they used radius or how the crow flies. Well, that raised some concerns in the public hearing from some other folks about radius versus distance. What we found out is that basically if you're about 15 miles in a radius from another hospital, it takes you about 25 miles to drive there. Originally to address this problem, although we did not ask for it, some hospitals asked clarification. We asked the department would it be possible as a technical thing to define that distance as really 25 miles in the way you drive by the miles. They looked into it and we're willing to do that, but then on further examination, they talked to us and said that there was some complications. We are using radius in many of our other standards including this standard, and it would be difficult to switch for this one provision, and it would also introduce a level of uncertainty because if you ever log into Mapquest and Expedia and all the other things, you'll find they pick different roads and the drive times can be different and the miles can be different, depending on what route you take. The department explained to us that they did not want to be in a situation where there was some dispute or some vagueness about what the miles actually were. If you use radius, there's never any dispute. You are either within that radius or you're out of that radius. So, as they explained that to us, they came back and said that they wanted to offer language to reduce it to 15 miles radius, which sounds like a substantive change, but actually gives it the same 25 miles between one hospital to another. When it was explained that way I was comfortable with it. I do understand some folks that have sat around the table with the MHA and the other hospitals who felt that in this instance, it was not a big deal, it's still keeping with the spirit of the original intent. It brings in four additional hospitals so the total would be 12 affected hospitals instead of eight. These folks were not concerned about the actual substance, but they did make a point that MHA also agrees with, and that in the future if there is a more substantive affect, they would not want the department to make a change without coming back and having a full discussion about it. I feel comfortable with that as well. They sent that explanation. The MHA feels that the department's language is acceptable. We really want this to go forward. No matter what happens today, we hope you will take final action on the language and allow the original hospitals who are counting on this proposal to help them get access for their patients to move forward.

CHAIRPERSON TURNER-BAILEY: Are their any questions? Ken Trester.

KEN TRUSTLER: Good morning. I'm Ken Trester, Senior Vice President for marketing at Oakwood Healthcare in Dearborn and serving western Wayne County. I'm here to just support the amendment that was offered by the department with regard to the unit versus the service question for MRI. Our initial concern with the language that was originally proposed was that we would be unable to locate a fixed Venus MRI unit for which we really qualified under all the standards, at a place separate from the MRI unit that currently resides at Oakwood hospital in Dearborn. We wanted to put it in a facility that was across the street, which we are constructing for the purpose of serving ambulatory patients. The language would have prevented us from doing that. In working with the department, we believe that the change that they are proposing, which would keep the previously defined definition of the MRI as a unit rather than a service, will be sufficient to allow us to do that. We support that kind of language that would give healthcare institutions the flexibility to really locate the MRI services, which are valid under this particular new standard, to the most appropriate place. That would allow us to do that. We are supporting that language. Thank you very much.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Barbara Jackson.

BARBARA JACKSON: Good day, I am Barbara Winston Jackson, with the Economic Alliance for Michigan. I just wanted to make a few remarks about these MRI standards. As we stated at the March 9th Commission meetings, we do support this action to modify the standards. We understand that the small-enrolled hospitals without fixed MRI services need to take care of the patients who are currently being serviced by fixed units. We feel this balance is a concern with patients at a smaller or rural facilities that require greater access to the MRI service, while at the same time preventing access purification of units. We continue to encourage modification of standards to establish the Commission's procedures, as opposed to potential legislature. However, we do have concerns about the process used to modify these standards. In a formal group met to develop a proposal and came to consensus on a specific set of criteria. However, very late in the process, following both the hearing and the meeting where the proposed action was taken, a change was initiated regarding the distance radius. In this case we do understand the need for this technology to render quality patient care, and we'll continue to support this language. But in the case of future changes to the standards, we will not necessarily support 11-hour changes to agreed upon proposals that have become approved language. We want to commend the many people who worked so diligently to address this issue, including Commissioner's departmental staff, MHA and providers. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Do we have any questions? Robert Marquardt, were you looking to speak to this issue?

ROBERT MARQUARDT: No, not now.

CHAIRPERSON TURNER-BAILEY: I don't have any further cards on the Magnetic Resonance Imaging.

CHAIRPERSON TURNER-BAILEY: Commissioner Sandler?

COMMISSIONER SANDLER: Yes, I would like to make a comment. It will go along with what Barbara Jackson's testimony was. I'm a liaison on this issue, as you know, and Amy brought this to my attention like last week about this change. I will tell the Commission members what I told her, that I have some concern about changing this at the last moment. I believe this is within the spirit of the original concept, but it does change ambiguously from eight to twelve, which is ten percent more. I would not support this unless everyone was at the table in our original meeting also supported it, and they have. Economic Alliance does support this, MHA and MSMS, the department, all of the groups that were there at our original meeting on May 4th are supporting this. I'm not going to push the Commission to support this. I'm not going to remain neutral, in a sense where I'm not going to push the Commission to support this. If the Commission feels comfortable with this 11th hour change, I believe that it is still within the spirit of the original but it does change from eight to twelve, which is a relatively small number, but considering 150 to 170 in the state, including the pipeline. That's up to each of the Commission to decide. The only thing that I would ask the Commission, if they preferred the original, that we take final action today. Thank you.

CHAIRPERSON TURNER-BAILEY: Commissioner Hagenow.

COMMISSIONER HAGENOW: I just wanted to say that even though there is an issue around last hour changes, it seems to me that if it's within the spirit and all of the original people are confirming it, it's really in the spirit of getting things done. That's very positive that that's there, so I don't see it as a negative, I see it as a positive that there is a willingness to take that exception. I would move approval on the standards as they are currently written.

CHAIRPERSON TURNER-BAILEY: With the amendment?

COMMISSIONER HAGENOW: Yes, with that change.

CHAIRPERSON TURNER-BAILEY: And moved by Commissioner Hagenow to accept the standards with the amendment.

COMMISSIONER MAITLAND: I support it.

CHAIRPERSON TURNER-BAILEY: Supported by Commissioner Maitland. Any discussion? Commissioner Deremo?

COMMISSIONER DEREMO: A point of order given that the language was changed by the department and not necessarily proposed here by Oakwood Health Systems. Do I still excuse myself from vote?

RON STYKA: I don't make rulings. It's really up to you as to whether or not you feel that it is a conflict and then the Commission has to rule on whether or not to agree with you.

COMMISSIONER DEREMO: It doesn't seem to me that this is a conflict of interest, but I will bow to the rule of the Commissioners.

COMMISSIONER SANDLER: I personally think it is not, because then how many MRI's, CT's-same thing with Mt. Clemons General, Genesys, the hospital administration's physicians wouldn't be able to vote on anything. If you want to use that as long as you're not pushing something. I personally do not consider it a conflict of interest.

CHAIRPERSON TURNER-BAILEY: Any further discussion on the motion? I'm going to ask the Commissioners to raise your right hand and we'll vote. All those in favor of accepting the language with the amendments, please raise your right hand. Opposed. It's unanimous.

COMMISSIONER SANDLER: We do understand the language?

CHAIRPERSON TURNER-BAILEY: That was my question.

BRENDA ROGERS: Just for those out in the audience that means that we're moving to forward for the 45 day review period with submission to the Joint Legislative Committee and the Governor.

CHAIRPERSON TURNER-BAILEY: Thank you. Nursing home and long term care unit beds and formal work groups. Commissioner Cory, will you give us a status report. Will you pass the microphone to Commissioner Cory, please.

COMMISSIONER CORY: Thank you. The Informal work group has spoken twice now, and they have gotten a considerable amount of work done. A couple of reasons for the establishment of this work group: One, it's perceived that some of the rules and regulations of bed mythology and so on is outdated. Perhaps we might want to revisit these issues to make sure that they are up to date. Also, placement and acceptance of nursing home beds are becoming more and more consumer driven, which I think is great. The consumers and most of the professionals I think agree that privacy should be enhanced. There should a promotion of greater dignity and there should be an increased quality of life for the residents. That's not to say that current nursing homes are bad. It just says that we can do better. The other thing that's happening is the physical plants of admitting nursing homes throughout the state of Michigan are very old, and people are having a difficult time keeping things together. By revisiting some of these issues, we think that some of the infrastructure can be and should be redone. So, these are some of the purposes for the meeting of the work group, which is comprised of members of the various trade associations and the department. One thing that we are talking about is a pilot project that would be limited to five projects for four years for a total of probably 20 projects. It would be based upon concepts that promote the greater dignity and enhancement and quality and so on. Also to be less restricted on some of the regulations such as square footage requirements for nursing homes. Also, to promote a higher degree of private rooms, single rooms. In terms of applications, there would be a set window for applications at a specific time in the year. And then the application round would be the next year, and so on. There also needs to be comparative review criteria developed that will include the assurance to continue to serve the same customers. Also criteria will be developed for replacement outside of the replacement zone. Also we feel that it must be compliant with the applicable design standards identified in the standards for health care facilities. Additional licenses would also be issued based on the number of sites. Another concept that we have debated about is what size should these new structures be. It's not set in concrete but so far the

construction for the pilots should be no more than 100 beds. That still is subject for further debate and researching. Also new construction should assure, and I think I already mentioned, the vast majority of these beds was the private rooms. The percentage that we're looking at right now is 85 to 90 percent, but again that's not set in concrete. Another important factor is that all of these beds under the pilot programs be duly certified for both Medicare and Medicaid. Also we feel that there should be a research and evaluation component to this so that during the tenure of these projects, there can be viable evaluations. These criteria are yet to be developed. If the rest of the Commissioners think that this work group is a good idea, our plan is to bring final language in the June meeting. So things are moving along quite well. We feel that that's very possible. So, I don't know what action needs to be taken at this time, whether your acquiescence will then determine if this is enough or whether we should have a vote with the Commissioners. Thank you.

CHAIRPERSON TURNER-BAILEY: Well, I'm going to assume that my acquiescence is enough and I would like to request and, in fact, thank you for continuing your work with the work group, and we look forward to the language. Are there any questions? Thank you. I don't have any cards on this issue. Unity Health. We had a discussion that was tabled from the February 26th CON special commission meeting. We said that we would take this issue up again. At this time, we also at that time then motioned the set up of a Standard Advisory Committee, which comes up later on the agenda, but I think we related it here. Is there any discussion among the Commissioners on this issue? I know we just received some material, which the people will have an opportunity to take a look at that. I do have one card on this issue. Are the Commissioners interested in hearing public comment before we get into our own discussion? I think that might be useful. Reverend Patrick Gohagan.

REVEREND PATRICK GOHAGAN: Good morning, madam Chair and to the Commissioners. My name is Patrick Gohagan and I'm a pastor of Emmanuel Lutheran Church, which is located on the east side of Detroit. It's probably a quarter of a mile for the proposed site for the Unity hospital that the Community Health department is proposing today before you. Before I speak, I would like for all of the people from Detroit who came down on buses or church vans to please stand up for us. Amen, thank you very much. So, I stand before you today, and I know you have a decision to make about a certificate need. And today as I stand before you, I just want to speak about a reality of need. That's the reality of the community in which I live and serve. The need to more access to health care, and especially for health care for those who are insured or under insured. Any one that lives in our community knows that there is a lot of life in our community, a lot of joy and a lot of love, but there is also a lot of death. From poverty to mortality to high morbidity due to violence, due to heart disease, diabetes, whatever it might be. There's truly a need for a health center to be in our community. I've been a pastor now for six years of Emmanuel Lutheran church, and I believe it was about a year or two after I got there, that the old Mercy hospital closed down. I don't know if you've ever been part of a hospital closing in a community, but what it did to our community was give us a devastating blow in many ways. Just the knowledge that a hospital that was sort of at the center of many things and activity would actually close. Right now there's a lot of excitement over what's being proposed here. I know it won't be on the scale that Mercy was, we understand that it's a step forward. We do know that there's a problem with access for people in our community, the hospitals, and also a problem with the hospital that offers respect and dignity to those who were served. We believe that the meeting with doctors and hearing much about the proposal, Unity has before me today, that we further stand in support. We all had to get on a bus this morning at 7:30 am, which I know for others, and at least for me that's getting up pretty early. That shows you that our true feelings behind this proposal. You see the people that are here today, and we're here as a community to offer our support and hope you would, indeed, give your okay to the Certificate of Need at this time. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Donna Littlejohn.

DONNA LITTLEJOHN: Good morning, Chairperson Turner-Bailey and other members of the Certificate of Need Commission. I am Donna Littlejohn, Executive Director of Mercy Primary Care Center in Detroit. We are located at the Samaritan Center. I'm pleased to be here this morning, once again, to give you some additional information about Samaritan Center. As I stated in February, the building at 5555 Conner and the new address on the east side of Detroit, housed the Mercy hospital. It is now owned by Samaritan Center Incorporated, not Trinity Health. Please let me tell you briefly how this change came about. Upon the closure of Mercy hospital, Trinity Health at that time was called Mercy Health Services. They had extensive discussions with the residents

on the east side of Detroit, as to how the building would be reused. It was at that time very clear, very clear, certainly clear, from these discussions that no one wanted an eyesore, a building to be closed. Additionally Trinity Health, given its concern about the service needs of the residents, desired to maintain a non-profit mission on Detroit's east side. To effect this transformation, a decision was made to engage a consultant and that consultant was dynamos to determine the uses of the building. Those discussions continued to look at the different possible feasibility, possibilities of that building, and also trying to take into consideration the desires and the needs of the residents of the city of Detroit. Additionally, Trinity Health wanted to enable to maintain its ongoing mission in the city of Detroit as well. These elements mainly included what the residents desired, what was actually feasible, and about the continuing non-profit mission. From these discussions, there was a coalition of a request for a proposal for a non-profit organization that would have the ability to least the building to the tenants who were desiring to provide services on that campus to residents in the Detroit area. The decision of Trinity Health to donate the Samaritan Center for $1, and the current mix of tenants today was a manifestation of that plan. Last February I provided with you with a list, and I think I have flyers so that you can see the many tenants that are available and providing services at the Samaritan Center. Those services included social service training, family assistance, job training, social service agencies, excuse me, and et cetera. The fact of the matter is that these agencies were able to serve more than 600 people per day on average. Approximately 18,000 per month. These 86 tenants are located in the 300,000 square feet Samaritan Center building as well as two buildings, the Pavilion building and the ancillary building, with about 20,000 to 80,000 square feet prospectively. Subsequent to last February's hearing, we had an opportunity to review the proposal, to put a 200-bed hospital at the 5555 Conner building. We believe that 1,500 square feet is required for bed. I'm sure that planners at hospitals would make similar conclusions. This requirement, however, does not suggest that each room, in which a hospital bed has an average of 1,500 square feet, but it means that when one plans a layout of space within a hospital, that that space allocation must be provided or provide all of the services that are necessary for hospital. That is a laboratory, radiology, services for a reception, intake person, supply closets, administrative offices, et cetera. Given the unoccupied space at the Samaritan Center Building that may be available for least, perhaps about 70,000 to 111,000 square feet, there only could be about a 46 to 74 bed hospital in the building. Given the occupancy and the space used by the tenants. Also, the infrastructure component such as complex air handling, computer and telephone systems, would also need to be added to the building to convert it into a hospital. In February, I advised the CON Commission that Trinity Health closed Mercy hospital due to incredible operating losses. Which over a period of 10 years from 1990 to 2000 totaled approximately $100,000,000, and $2,000,000 per month at the time of closure of the hospital. Trinity Health at that time wrote off $45,000,000 from its balance sheet, which was the book value of the building following the closure of a hospital at Mercy. Unfortunately Trinity Health is no longer its owner. Trinity continues to amortize the tax indebtedness on the building. Annually this obligation is $3,000,000 per year. Additionally, as I previously advised, Trinity Health has a 10-year lease for this space within Samaritan Center to operate Mercy Primary Center. As you know it is a center that provides healthcare to the uninsured ages 18 through 64, who do not qualify for Medicaid, Medicare, private or public funded healthcare coverage programs. Annually Trinity Health also commits $2,000,000 each year towards the operation of Mercy Primary Care Center. Without this clinic, which has a patient compliment right now of about 3,100 individuals, patients, residents would not have access to primary healthcare or they would not have a medical home. Consequently, Trinity Health contributes $5,000,000 per year as its continuing community investment, $3,000,000 in debt service and $2,000,000 in the operations of its ongoing mission on the east side of Detroit, the Mercy Primary Care Center. In summary I'd like to say that Samaritan Center is viable and it's alive. It has become the multi-service resource center for the residents on the east side of Detroit. That it was intended to be. Samaritan Center is a trusted friend, a partner and it's recognized as a one stop access point for the many complex health, social, economic and spiritual needs of the residents on the east side of Detroit. The beauty of this is that one resident actually said this, and it just struck me, it stood it in mind, is that she said "you know what, you can go to Samaritan Center and get all of your Social Services needs met right here in this building". Notably more individuals use the building today and derive benefits from the various services, then when it housed the former Mercy hospital. As such the mix of services and their acceptance by the community validate the vision for the region of the building. In closing, please let me acknowledge that the use of the space with Samaritan Center rest with Samaritan Center Incorporated, the owners of the building. Thank you for the opportunity to appear before you today.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Ms. Littlejohn, we have a question

for you.

COMMISSIONER HAGENOW: It sounds like there's a comprehensive outpatient ambulatory service. In your mind, how are the needs of the acute care being met for that particular region?

MS. LITTLEJOHN: Well, as I mentioned in my testimony in February, the acute care needs is not just a Detroit problem, but it is a national problem. Our goal at Mercy Primary Care Center is to try to meet individuals half way. Many of them have not seen a doctor. Some of them in 20 years. As I testified in February, we had one individual who had gone to the emergency room 26 times. After coming to us and finding a medical home, he has not gone back to the emergency room. My answer to you is that there's a bigger question than I can answer for you.

COMMISSIONER HAGENOW: So, what you're wanting us to consider is that the importance in weighing the value of this ambulatory outpatient creating a medical home and let somebody else solve the problem as it relates to acute care, from your perspective?

MS. LITTLEJOHN: From my perspective what I'm saying is that there is a need for primary healthcare, but there's also a need for inpatient care as well. What I'm saying is that the decision does not lie with us, it lies with Samaritan Center. They're the owners of the building. I just would like it to stay there.

CHAIRPERSON TURNER-BAILEY: Commissioner Sandler.

COMMISSIONER SANDLER: To follow up on Commission Hagenow's question, no matter how good your clinic is some patients, regardless of the clinic, rather it be the University of Michigan, Henry Ford, or the Samaritan Clinic, some people need to be hospitalized. Where do the patients presently go for hospitalization in your area?

MS. LITTLEJOHN: The patients go to the neighboring hospitals; Riverview hospital or St. John's hospital, or Henry Ford hospital. As you know St. Johns did close one of their hospitals, but their emergency urgent care area is open to individuals. Again a primary care center can't solve all the problems of a community. I think that's why it's important for linkages to occur and we have done that with St. Johns and Henry Ford by working on a memorandum of understanding for certain kinds of services.

COMMISSIONER SANDLER: What kind?

MS. LITTLEJOHN: For example, if there is a patient who comes in and they need to have, let's say they have Hepatitis C and they need to have a liver biopsy, we have a relationship with the Henry Ford Health System for that person to go in and see a specialist, in which we pay for. The patient pays for nothing. At that time if there is a definitive diagnosis that the patient needs further treatment, we can get emergency Medicaid for that patient, and again the hospitalization to be cared for. It's a win/win situation.

COMMISSIONER SANDLER: Thank you.

CHAIRPERSON TURNER-BAILEY: Are there any other questions? Commissioner Goldman.

COMMISSIONER GOLDMAN: I understand you're saying that Samaritan Center owns the building so they're responsible. As an individual who runs a primary care center within a building, there is somebody who has to make the kind of choices that you just discussed about where you send certain patients for additional work up or perhaps for inpatient care. What is your feeling about having a facility, even if it is a small facility, 46 to 74 beds, within the actual building that you could potentially refer patients to should they need inpatient care?

MS. LITTLEJOHN: That's a very good question. Again, as I mentioned in February, I just wish I had a magic wand to look ahead to see, but I have no comment on that. Our goal is to try to make sure the needs of the community are met. That's our goal. However that happens, that's how we would like to do that. Again, the decision rest with the Samaritan Center in terms of who goes into the building and who is not allowed into the

building.

COMMISSIONER GOLDMAN: I understand that. I guess the question that I'm asking you is that you are there on the ground seeing the patient population everyday. We're up here in Lansing and we're somewhat removed and we're just interested in any feeling you have about with the patient population that you see everyday benefit from a facility in the building or do you think that their needs are adequately being cared for with the referral system that you currently have in place?

MS. LITTLEJOHN: The patients that we see are uninsured. I think that's the bottom line with all of this. Will they get the same level of care at a community hospital. That's sort of my contention, bone of contention there, just to make sure that the uninsured is cared for. However, they're cared for, whether there's a community hospital in the building or external to the building is fine, as long as the mission that we have, and the ministry that we have in the community serves the needs of the uninsured. I have no further comment.

CHAIRPERSON TURNER-BAILEY: Commissioner Deremo.

COMMISSIONER DEREMO: Thank you for your testimony. There are 86 tenants and those 86 tenants comprise about 400,000 square feet?

MS. LITTLEJOHN: Approximately 300,000 square feet.

COMMISSIONER DEREMO: And there's another 100,000 in the ancillary support service. Now the primary care clinic itself comprises of how many square feet?

MS. LITTLEJOHN: Of about 12,000 square feet. And we were formerly housed in the emergency room area of the former hospital.

COMMISSIONER DEREMO: So, the rest of the space is really related to other services that are Social Services rather than healthcare services, although we know there's an integration of healthcare and Social Services and their needs?

MS. LITTLEJOHN: Yes. There are healthcare services provided. The percent of dialysis is also very close to our wing. We have quite a bit of square feet, I think it's about 10,000 square feet. Also there's a primary care office there too that provides care for adults and children who have insurance, Medicaid, Medicare, et cetera. So, you have a lot of healthcare services that are ambulatory there, right there on the premises.

COMMISSIONER DEREMO: So, your contention is that if Unity Health were to occupy the building with the size of the hospital, that they're proposing that the majority of the tenants would be displaced?

MS. LITTLEJOHN: That was my original testimony in February, that is correct. That is also my testimony today. However, the decision is up to Samaritan Center and not Trinity Health.

CHAIRPERSON TURNER-BAILEY: Are there any further questions? Thank you. Linda Williams.

MS. LINDA WILLIAMS: Good morning. My name is Linda Williams and I'm a registered nurse. I was supposed to be working today, but I thought this was important enough for me to call and ask to get the day off. I was approved that. The perception of the clinic that is there presently by the community is that there isn't really one there. There are a lot of people in the congregation of Emmanuel Lutheran that didn't even know about it. I am not a member of Emmanuel, but I happened to be there at their service on Sunday when the pastor announced this. So, I thought it was important enough to go with a church that I don't even belong to, and come up to this meeting. The young woman who just spoke said that the one person said that they were glad that they could come there. It was the one place to have their Social Services met. Social Services are very important, but good health is very important too. Even if the 200 beds that Unity is asking to have be placed there cannot be done, to have a small percentage there would be good. The 45 or 50 beds, I think, will be helpful in that community. The people who live in that community, the ones who are uninsured, who don't have transportation,

can't get to the hospitals that are around. They can't get to St. Johns or Bon Secour or Henry Ford. I happen to work out in the suburbs, and there's very few Detroiters that I see coming out there, much less people who don't have insurance. I think what's important is that when you ask, Trinity hospital did not make it there in that neighborhood, but I'm hoping that you will give Unity the opportunity to at least to try to do that. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Commissioner Hagenow.

COMMISSIONER HAGENOW: When you said distance, I'm not familiar enough with Detroit. How far is it to go to the closest inpatient acute care hospital by the roads? Like driving, because I realize in Detroit you have to go where the roads are?

MS. LINDA WILLIAMS: You have to go where the roads are. I would say where Chandler Park is to where St. Johns is, which is on Outer Drive, which is probably----Oh, St. Johns is closed. That's Holy Cross-. I live on the west side of Detroit and I work in the suburbs. So, Bon Secor would be the next closest, right? About five miles of city driving without having a car. So, we're talking about maybe taking the bus or a cab.

COMMISSIONER SANDLER: It's more than five miles from Mercy hospital or Bon Secor. That's from a native Detroiter. That's further than five miles.

MS. LINDA WILLIAMS: I was thinking it might be closer to 10 or 15. I've only been to Bon Secor once.

CHAIRPERSON TURNER-BAILEY: Are there any other questions? Thank you. Did you sign the sheet?

MS. LINDA WILLIAMS: Yes.

CHAIRPERSON TURNER-BAILEY: Thank you. Lonnie Joe.

DR. LONNIE JOE: Thank you, Madame Chairperson and Commissioners. If possible can I defer just for a moment and follow the legal counsel for Unity, Mr. Steven Scapelliti.

CHAIRPERSON TURNER-BAILEY: Sure, Mr. Scapelliti.

MR. STEVEN SCAPELLITI: Good morning, Madame Chairperson and members of the Commission. Thank you for this opportunity to be before you again this morning. When we were last before you in February, on February 26th of this year, we came to address the question of need for healthcare on the east side of Detroit. Since that time there's been a lot of discussion, both before this Commission and outside of it. I have yet to hear anyone challenge the needs that exist on the east side of Detroit, as well as the city of Detroit in general. Certainly with respect to the community in which we are looking to serve, you've heard testimony today from people who first hand had to see the need on a daily basis. Instead, there's been opposition with respect to the state. I do not intend to belabor the point. We addressed this back in February. In our discussions with Samaritan Center, Incorporated, the space that we have sought to occupy will not displace other tenants. We have renewed those discussions since February 26th. There has been a number of items of communication that has gone back and forth. As recently as a week and a half ago, I met with counsel for Samaritan Center, Inc. with respect to the space. As a result of those discussions, a proposal was made by Community Health to Samaritan Center, Inc. with respect to actual terms of release. We have been advised by officers of Samaritan Center that sufficient space still exist at the location. It will not result in the displacement of the tenants. That being said, we have provided each of you with a group of exhibits that we feel are supplementary to the business plan which was provided the last time we were here. I just wanted to go over those exhibits with you briefly, to give you a little bit of guidance for your review, and I'll expect it will be at a later time. Since we were last before you, we appeared before the Detroit City Counsel. The City Counsel voted to approve a resolution of support for Community Health LLC and the hospital project to be located at 5555 Conner, in the City of Detroit. That resolution is part of your packet. It's followed by a letter dated April 2004. A letter of support to this Commission by the whole City Counsel, signed by the Counsel president and each of the members. You also have before you a letter from Warren County Development Collision, a community group which is extremely active in that community, which has provided its support for this project, and has requested that this

Commission use whatever means that are available to approve and assist in the opening of this hospital. I've also provided you with a copy of the formal proposal, which Unity Health has made to Samaritan Center, Incorporated for a lease. There are items of correspondence that will present evidence, that are self-evident. There's an August 3, 2003 letter of intent between Community Health and Samaritan Center, which was basically our prelude to the discussions that we have had at this point with Samaritan Center about moving towards an actual written executed lease. There are also items of correspondence between Pastor Reverend Joseph R. Jordan to Trinity Health and Trinity Health's response to Reverend Jordan indicating that Trinity Health has no interest in healthcare in the city of Detroit. The letter was wishing him well and suggesting that he and Community Health look to be of assistance to the city of Detroit with respect to questions of healthcare. We also had an early letter if intent from Samaritan Center dated July 12th of 2002. It's a draft letter where counsel for the two parties were in a discussion concerning the appropriate terms for release. That letter again is over a year and a half old, but suggest that there were communications going on for some time concerning this phase. Most importantly, the last exhibit in the packet is a lease for a hospital which was executed July 27th of 2001, between Samaritan Center, Incorporated and another group called Medical Investment Associates, Incorporated. The results of that relationship was that the intended tenant although occupied the space for a year, was not able to move forward and get the financing that was needed, and it left the space. It is clear that Samaritan Center, Incorporated, has had intention for quite some time to replace Mercy hospital with a new hospital. Now among the doctors I give you, as I said in this letter----- I should say a draft document dated July 12, 2002 between counsel for Samaritan and myself. In that document it makes specific reference to a grant agreement between Trinity Health and Samaritan Center, Incorporated, and references the fact that whatever reasons executed will be done in conformity with those terms. It is my understanding from my discussions with counsel for Samaritan Center that the previous lease, the July 27, 2001 lease, also was done with the knowledge and approval of the grant for that space. Now, I appreciate hearing today that whatever is to happen with that space is between Samaritan Center and Unity Health, LLC. That has been our intention all along. As I said, no one has questioned whether there is a need for a hospital on that side of town. The feasibility of the hospital, we think we have demonstrated adequately through our business plan, at least from an overview standpoint. Clearly there is much more that goes into planning and creating and establishing a hospital, than can possibly be put in the terms which we have provided to this Commission. Our understanding was that we were here to address the need, although we are pleased and happy to address anything with respect to the feasibility of this hospital and its success. We have a five-year business projection, which indicates to us without a doubt that the pyramid in that community is more than sufficient to support a hospital with 200 beds, even a hospital with 350 beds, which formerly was there. I can't address the reasons why Trinity Health decided to close that hospital. I understand what they told us and I certainly have no reason to doubt that, but our projections, our experience, the experts with whom we have consulted, have precluded that a hospital is viable in that area. It is our intention to press forward with this, with your help, with your assistance, and hopefully with your support in this project. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Commissioner Sandler.

COMMISSIONER SANDLER: How many beds are you thinking of starting with?

MR. SCAPELLITI: We would like to start with 200 acute care beds.

COMMISSIONER SANDLER: On the first day you open?

MR. SCAPELLITI: No, well, we will wrap up---- we expect to start with 100 beds over the first six months to 200 beds. We anticipate wrapping up as quickly as the need arises, which we believe will probably be faster than six months. Quite frankly, given what our experience has told us, we open this hospital with 200 beds and the patients will be there. This is through discussions with physicians as well as experience with some of the principals of Community Health. Dr. Joe addressed that issue as he and another principal at Community were at Mercy site prior to its closing, has quite a bit of experience with respect to the patient intake of that location.

COMMISSIONER SANDLER: Thank you.

CHAIRPERSON TURNER-BAILEY: Commissioner Young.

COMMISSIONER YOUNG: Say we assume that need is there, and we all agree that the need is there. We've received some correspondence like a couple of weeks ago about the Samaritan Center, the owner wasn't interested in having a healthcare facility. Has that changed? Are there any other people interested in the space? Can we definitively say that you have lease space that's concrete or is the city just in the proposal stages?

MR. SCAPELLITI: Well, as I stated previously, Commissioner, the discussions have been going on with Samaritan Center for some time. As you'll see as you review those documents, the terms that we have discussed in the past are basically the terms we have discussed presently. To answer your question directly, yes, I believe that what was contained in that letter, which we saw approximately a week and a half ago, is different from what the actual intent of the Samaritan Center is, because as I said I received that letter, I contacted counsel for Samaritan Center and in a meeting we discussed whether the space was available, we discussed whether there was intention for the hospital to be there. We certainly don't want to waste our time if, in fact, the space is not available. I can't speak for Samaritan Center as to what their reasons were for sending that letter. I have my suspicions as to why it was, but following that discussion----I'm sorry, but following that meeting I had another telephone conversation with counsel, and again, was told that we could submit a proposal for the space. Now, I don't expect someone to be paying an attorney to call me to tell me to submit a proposal if, in fact, they don't intend to enter into those discussions. I could be incorrect, but my belief is that, yes, they do intend to enter into a lease if the terms could be agreed upon.

CHAIRPERSON TURNER-BAILEY: Commissioner Goldman.

COMMISSIONER GOLDMAN: So far the discussion is perceived under the assumption that there's been a demonstration of need, but I thought the reason you were here is that the numbers that we have for the city of Detroit indicated that there is no demonstrated need for additional beds. I wish in the end that your concern in people here and I understand what we were told in January about the need in that area having to deal with availability and accessibility, but I don't like to overlook the fact that, in fact, there is a legal requirement that we do have to deal with. Would you agree with that statement?

MR. SCAPELLITI: I would agree with that, yes, Commissioner. If I may respond further, we are as sensitive to that as anyone. We recognize before this Commission asking you to grant a new standard that will allow beds over and above what your current methodology provides just for the purpose of being able to take care of the need if we feel as if it's not being met. We are in discussions with other area hospitals about the possibility of using existing beds within that community, so we do not have to be asking for additional beds. Again, depending on how these discussions go forward, may still require that there be additional actions by this Commission to accomplish that.

COMMISSIONER GOLDMAN: I guess my concern is the presidential nature of this, if it is true that you can look at need in a different way from the way that we've looked at it in the past, then the same argument would apply to need in Livingston County, in Oakland County, in Macomb County, and other counties where the bed need methodology indicates that there are adequate beds, but someone comes before the Commission and says, but not in this portion of the county, or not in this residential area, because of lack of transportation, because of traffic, because of other reasons. I'm worried about the presidential issue.

MR. SCAPELLITI: I would expect that you would be, Commissioner. I believe that the city of Detroit presents a rather unique situation, unlike anything else in the state. If you look historically at the patterns of hospitals, at how hospitals were merged into systems, and how for a variety of reasons, again, none of which I would attempt to address before this Commission today, but for a variety of reasons, hospitals have had to close. Beds have remained in the city, in great part, perhaps, because of the fact that the way that our Legislature prepared or drafted these Certificate of Need laws, and have amended it over the years, this is the quandary that we now find ourselves in. This is why we have come before this Commission to ask to consider this particular issue. It would not be the first time. You've had pilot programs which were intended and directed at addressing situations that could not be addressed by the current methodology. As those pilot programs were instituted and the need for the standard was phased out, those standards were taken off of the books. We see this as yet

another unique situation. Certainly one, for lack of a better term, is a matter or life or death. Certainly for those on the east side of Detroit. But, yes, I would expect that this Commission would be sensitive to a precedent that it might set as a result of this.

CHAIRPERSON TURNER-BAILEY: Commissioner Young.

COMMISSIONER YOUNG: The question for the department is, does the department have any concerns about this issue or not at all?

MR. CHRISTENSEN: We definitely have concerns about the whole issue of access to care, as well as the other business questions that have been asked about the viability and if there's space. The additional documents that Unity has given us today related to the lease terms provided a better level of comfort regarding any of available space. Of course, even if they were to get the city to bend, it would require a change in the standard in order to do that, and you don't have precise language in front of you at this time that would amend the standard to accomplish that. We have been working very hard on this issue, looking at all the documents that we could and all the available information, and we feel that it might be possible to put together a proposal that the department could support, in terms of this issue, but it depends on negotiations with a lot of different parties down there. I think the point that Dr. Goldman made about the issue of available bed need is an important one. We're over bedded in Detroit. That's the bed need methodology that this Commission just recently looked at and debated. The department had some reservations about that bed need methodology. I think we've made our points known, but agreed to support the bed need methodology if we could take a hard look at access to care, and that's a subsequent item on your agenda today. We would not urge, however, that this issue be automatically referred to any Standards Committee looking at access to care, because that action is an action that will take about six months, and by the standard operating period for the special Standards Committee that we hope they're going to act on a little later today. In addition, if it is thrown into that Standards Committee, what could very well happen, and it's a Standard's Committee rather than taking an objective look at the standards, tries to create a standard that neither will accomplish or not accomplish the issues that Unity may want to achieve. So, that puts an element of a preconceived result into----or at least question a preconceived result into the Standard's Committee. So, we would like the Standard's Committee to be appointed and given its charge without having to solve a particular problem, but rather look at the issue of access to care statewide. We would recommend that if the Commission is comfortable, since you actually can't take action on it today because you don't have any language in front of you, to either accept or reject, that we table it until the June 15th meeting, and put it on that meeting if the Commission is comfortable with doing that. By that time we should have completed our rounds of discussions with the variety of principals in Detroit. We maybe be able to make a proposal that would be satisfactory to all parties. So, the notion would be tentative on the understanding that the department would go forward with discussions in hopes of bringing some substantive recommendations back to us at our next meeting.

MR. SCAPELLITI: That's correct.

MR. CHRISTENSEN: We certainly would use that all diligence to achieve that. We've had a number of of discussions, but they have not reached a conclusion yet so we're not prepared to deal with responding directly to your question, what is the department's position because we don't quite feel we have the issue resolved in our mind yet.

CHAIRPERSON TURNER-BAILEY: Mr. Styka.

RON STYKA: I think this is a good time, as your counsel, just to make a couple of points with regard to the Commission and this statute. They are important, not just for this issue, but in general. Keep in mind, testimony like you've been hearing at the prior meeting, this meeting is extremely important. It brings up points as to whether or not there is a need somewhere where right now the standards don't address. That is very valuable for this Commission to do in this beginning process where most changes that occur with regard to the standards that you adopt. But the Commission really is not involved, or should not be involved by statute in manioca, such as is there building space? Is there a lease? Who was the evicted if there was a lease? These are matters that come up differently under the statute. Just quickly I'll just mention that your duties are laid out under section

221.5, and that is to develop, approve, or disapprove or revise certificate of need review standards that establishes for purposes under another section 2225 the need, if any, for among other things here in today's context, the beginning of a new health facility or additional beds. Section two of that same provision, 2215, says that the Commission shall exercise its duties under this part to promote and assure all of the following: A, is the availability and accessibility of quality health services at a reasonable cost within a reasonable geographic proximity for all the people of the state. So, the kinds of testimony you're hearing in general here obviously go to that and are designed to peak the interest of this Commission as to whether or not it needs to change some standards or add a standard. Secondly, appropriate differential consideration of the healthcare needs rural versus statewide, et cetera, et cetera. But section 2225, which was referenced earlier, you're developing standards for youths under 2225, says that "In order to be approved, the applicant", and we're not even there because this will be down the road. "An applicant for a Certificate of Need shall demonstrate to the satisfaction of the department". Because you've created the standards that the department uses to judge individual applications. The satisfaction to the department that the proposed project will meet an unmet needed area proposed to be served. So, again, and I know you know this, but sometimes it's good to remind oneself of what's going on, especially when you hear such well spoken, well meaning people talk about things like leases. The details that the department would normally look at in reviewing an application, that the goal here and the duties here with the Commission is, is there a need out there somewhere, and do our standards properly address that. If not, do we need to change the standards. I think the last dialog between Commissioner Goldman and counsel here was a good one, because it got to those points. I just felt that I wanted to mention this because I know there have been new Commissioners within the last year or so. We've been getting into a lot of issues within the last year that sometimes involve a lot of the manioca. I'm not saying you're not doing your job properly, you are. That's the early stage of deciding, is there a need or something that we need to address. I just wanted to mention that. Here a year ago, if you decide and you think there is some sort of need, if it was accessibility, availability issues aren't being met. We want to revisit that. If we do how do we change the standards. Standards are not meant to say there shall be allowed eight hospitals on the east side of Detroit. There supposed to be a more broad, generally applicable, and although it may be in a process that may need only one hospital on the east side of Detroit, but they shouldn't be designed specifically for a project, but be broader than that. Thank you.

CHAIRPERSON TURNER-BAILEY: Commissioner Hagenow.

COMMISSIONER HAGENOW: With those words of guidance, I don't know if my questions are appropriate or not. I'm thinking in terms of if it was strictly on the basis of the standard, we would just say, you don't meet the standards in terms of bed needs, and then it would be done, right?

RON STYKA: Well that would be the department role. We have to decide whether or not we want to change that.

COMMISSIONER HAGENOW: So, my question gets to this access piece, because I think that's----if we're just going on statistics and numbers and number or miles or whatever, it would appear that the present standards would say there isn't a need. So, the question becomes, what is it that's so transcendent about this access to this particular area that it needs a different standard to be applied, and that we haven't yet created. I would like to understand that more. Five miles seems like a long ways in some parts of the world, and in other places it isn't. Coordination and connectivity seems important, but not necessarily that five miles is a long ways. I'm just trying to understand how you're really capturing the essence that access is not achieved at the present time?

MR. SCAPELLITI: I'll try to address this as specifically as I can. When we were here on February 26th—

COMMISSIONER HAGENOW: I'm sorry, I had surgery at that time, so I didn't hear it all. I have reviewed some of it.

MR. SCAPELLITI: We showed maps of the city of Detroit. We showed in 1998 on the east side of Detroit alone we had seven hospitals that shortly after Mercy closed, another four hospitals closed, now leaving only two hospitals to service the entire east side of Detroit. Within a year following the closing of Mercy, the emergency rooms at area hospitals, the closest hospital where Mercy was located, were flooded with patients. You now

have 12 to 15 hollow waste in the emergency room, waiting rooms in the city of Detroit. Unlike anything anywhere else in the state. When people wait that long to get before a doctor because there isn't adequate access in their community, in their particular community, you run the risk of people dying, or their conditions are getting much worse. Detroit, being as large as it, again it is unlike any other part of this state, and there's such a gap, such a geographic gap. Again, if I could refer you back to those maps, and hopefully you were given a copy of the PowerPoint presentation. There is an enormous area, like a desert, at the north end of the city. You had Sinai Grace on the one side and St. John main on the other and Riverview. We know from our discussions with the systems, they need help over there. So, whatever the methodology shows about the beds having been issued there, issued bed does not equal staff beds. Issued beds are held in inventory because the law allows them to be, and we wouldn't argue with that. But to look strictly at the number beds issued and also ask how many beds are staffed and available to the people in that community, does not enable you to answer the question whether there is need. That has been a significant problem. To look simply at the number of hospitals that are closed and then ask whether all of those hospitals surrendered their beds back to the state, I'm only aware of one that did and that was Mercy. The rest of them, those beds were purchased by other hospitals. You now have increased waiting times in the emergency rooms because the people are not being cared for. The doctors can tell you that. Again, Dr. Joe can address that better than I can.

COMMISSIONER HAGENOW: Maybe this is for him. When you get a large amount of patients going to the emergency rooms, the primary care isn't available not necessarily that acute care beds aren't available. So, the question is, is the need really for primary care and not necessarily for access to acute care beds?

MR. SCAPELLITI: Again, I'll let Dr. Joe answer that. I do wish to point out that the available records that we've looked at, at St. John's Riverview alone, their emergency room was set up or designed for 1500 patients a year, and in the Department of Community Health records showed that within a year, a year and a half, they were already at 32,000 patients. Some of those patients needed inpatient care. I know that we read a lot in the paper about people going into an emergency room because they know that they can't be turned away, because they know that if they go there and they get the care that they need and it becomes a problem for the hospitals, as far as collecting goes, but in these communities there's a lot of insurance. There's a lot of insurance. There's a lot of Medicaid, Medicare. There's a lot of commercial insurance. There's Blue Cross-. You have auto insurance as well. Our pyramid shows that the number of people attempting to use emergency rooms rather than going to a primary care, simply because the inability to pay. In fact, the study that was included with the materials we gave on February 26th, includes a report from the Senate Fiscal Agency of 2000, addressing the fact that uncompensated care, the Michigan house said that in particularly in the city of Detroit accounts for less than 2.5 percent of total revenues for the hospitals. That is insignificant, absolutely insignificant. So, we believe that, together again with all the other materials that we have provided, clearly demonstrates there's an unmet need. I would agree with you, Commissioner, if I looked strictly at the methodology, if I looked strictly at the fact that these beds were issued, the law does not require them to be turned back in. I too would say, perhaps there is a new need there, but I think with practice it shows otherwise. I would be more than happy to defer to Dr. Joe to answer your questions. I think he'll do a much more adequate job.

CHAIRPERSON TURNER-BAILEY: Commissioner Andrzejewski.

COMMISSIONER ANDRZEJEWSKI: I'll take a risk with my question. Setting that issue aside for a moment, I do have compassion for the people living in this area from what I've heard today, but let me ask you, how do you conclude that this can be a viable project in light of the history of this campus?

MR. SCAPELLITI: First that is a question that we had to ask ourselves before embarking on this. I've been involved in this project for three years. The principals at Unity have been involved for three years. They've been trying to reopen the hospital at that facility since Mercy closed. Some of the principals, Dr. Joe being one of them, is familiar with patient intake at that location. So, we know with the pair of mixes, we know what the demand is, what the need is in that area. We have available to us and have used the people who have made the projections of the anticipated revenue, the anticipated expenses. We have a five-year plan that clearly indicates profitability, for lack of a better word, this will be a non-profit hospital. But profitability and viability throughout the proposed 20-year lease at that premises. Again, nothing that I can go into in depth, but we have done our studies, we have made our analysis and it has been reviewed by other hospital professionals in the

community and no one has questioned or shot down the plan. They have all agreed that it is a viable plan. It's a lower cost, lower overhead, facility than a hospital that will be affiliated with a system. It is a stand-alone community hospital. It will not be all things to all people, but it will provide the essential acute care services that the community so sorely needs. These are services that were present at the location at the time that it closed.

CHAIRPERSON TURNER-BAILEY: Commissioner Sandler.

COMMISSIONER SANDLER: Yes, I have several comments about what Mr. Christensen said. First, as far as the Advisory Committee that we're likely to appoint later in the meeting. You said six months. Well, I think that's probably less accurate in the following sense. Six months won't be until June or the end of June. If they take six months, and there's a lot of issues, likely we won't need the whole six months. You're talking about coming back at the very earliest March 9th or March 10th. The March meeting of '05. Therefore, you're talking about at least 10 months or more from today's date. Therefore, if it's felt by the department that this is a need that needs to be addressed, I will second your concerns that this Advisory Committee will be more general and would not be timely in addressing that issue. Hopefully you just mis-spoke, but Commissioner Goldman is as we all know is a distinguished counsel. At the last he's not Dr. Goldman.

CHAIRPERSON TURNER-BAILEY: Commissioner Ajluni.

COMMISSIONER AJLUNI: In light of the comment by staff, I really don't want to cut out discussion, but appears as though we're heading for a tabling and I would like to make a motion to table this until the June 15th meeting.

CHAIRPERSON TURNER-BAILEY: I think that's fine, but I do have two more cards with public comments. I don't like to cut off comment if we don't actually have to.

COMMISSIONER AJLUNI: I would defer to the Chair. I would like to withdraw my motion.

CHAIRPERSON TURNER-BAILEY: As soon as we're done with the comments, then you can make that motion again. I do have a question just for clarification. You made a comment, Commissioner Sandler, about the time frame for the Advisory Committee, and we will discussing that probably after lunch. But the way the law is laid out now, that can't be stretched out, it has to be six months from today. If we seek that Committee today, they have to come back with recommendations within six months; am I right about that, Mr. Styka?

COMMISSIONER STYKA: It will take me a minute to double check, but I believe you are.

CHAIRPERSON TURNER-BAILEY: In the meantime, Dr. Joe. Thank you.

MR. SYTKA: It is six months where you would have to have Commission action on that. Which takes another 30 days for a public hearing, and then 45 days after that report.

COMMISSIONER MAITLAND: This is Maitland. For CON time, that's pretty quick. So, I don't want any new member to think six months to a year. We only meet quarterly, remember. What can we do with this poor Committee if they don't perform properly and report back in six months? Do we fire them and start over or do we send them to jail? I'm not clear. I didn't think there was. So, it went seven months, it doesn't make their recommendation void, does it?

COMMISSIONER STYKA: No.

CHAIRPERSON TURNER-BAILEY: Thank you, Dr. Joe.

DR. LONNIE JOE: Thank you madam Chairperson and to the Commissioners. First of all let me start by making it perfectly clear that the sentiment and the heartfelt comments from Ms. Littlejohn representing the clinic that currently exist at the hospital, are well taken and well spoken also. We've been of the opinion for a very long time, that the way hospitals operate in urban settings need to have this type of outlet, this type of safety valve to be associated with these hospitals simply because on going force basis in the future what we have to

deal with in terms of the sheer madness in terms of numbers, and having people find the right locations to be in. This is going to be a necessity. So, I think that Trinity should be applauded just for the idea of the intent to do this. However, we also know after years of experience in this business, that we can't bring a teaspoon full of solutions to such a running mill problem, we have to build on it. We think that Trinity has begun to provide some of the basis of the building blocks for this to continue. If we were as Unity needs to be successful in obtaining this space and opening up this hospital, and Trinity decided to leave, we would immediately seek the replacement for that clinic. As a matter of fact, we have already had some limited discussions with some types around the country to look into this, because we think that this is what it's going to take in the future. The landscape of healthcare has certainly changed. If that were not true, this Commission would not have had a committee to look at bed standards. Why, because there was something seriously amidst, and you decided to address it. Which as I read the preamble to the Constitution of the charge of this fiscal mission. I think this was brought out by one of the Commissioners in February that it is the charge of this Commission to constantly look for ways to improve. To constantly provide the exceptions to the standards, so that these needs could be achieved. So, with that in mind, I think that certainly what I've heard today means that you all are on the right track, in terms of making sure that this happens in terms of what happens for particular areas of need. If we were to look at this from a medical standpoint, we don't give drugs to people who don't need them. We don't give Antibiotics out inappropriately. We don't provide services, or we shouldn't at least for those of you with positions on the Commission can relate to this, but we shouldn't provide services that patients don't need. We have to take the services where there is a need. I think that the presentation that we made on the 26th on terms of healthcare did certainly demonstrate that there is a need for this community. I have relatives that live in this community, and I can identify with the problems that they have to deal with in terms of healthcare. In addition to that, we think that the bed issue as Commissioner Goldman spoke up in terms of numbers, as Steven mentioned, just to reiterate, we are in conversations with other healthcare systems where the total number of beds will not have to be increased in terms of what is assigned to the city of Detroit, but the beds have to be in the right location. We cannot fight a war if someone has the bullets and we have an empty gun. Those two have to come together in order to make a successful aim, fire and shoot. That's what it takes to change some of the healthcare instances that we occurring on the east side of Detroit. We would also like to just briefly say, that this issue is not going to go away. It will come back before this Commission, before the department, before the State, before the Medicare budget people, in some form, some manner if it is not dealt with in a timely manner. Therefore, my caution and concern would be that this issue gets stretched out to the degree simply because of the rules and regulations, to the degree that it becomes a project that gets set back or to some instances it may not be viable to achieve. I don't think that we should succumb to that law. I think that we have the intelligence, we have the intent, and we have the honesty of people like yourselves to actually say let's change the law and make it good now. Unfortunately we have a lot of bad laws in this country, but we can't change them all at once. One thing that we're dealing with here today is the inability to perceive two needs because of law. That's what we're asking. We're asking that through the process that this Commission operates under, through the guidelines, and I'm taking the counsel's words very seriously here, in terms of 2215 and 2225 in terms of what actually needs to happen in the process here because we feel time is of the essence in terms of doing this. We are committed to this project as a group. We think that if you can find any place else in the state of Michigan that will stand up and demonstrate need in a greater, we suggest that we all for it together because the numbers, the negative numbers from this community continue to be produced every single hour. Not every day but every single hour. We do realize that there are new Commissioners present. For those of you who did not get a copy of the business plan that we distributed on the 26th or any other information, we would kindly make it available to you through the department also. Lastly, I have been made aware that there are some concerns concerning financing and whether or not a hospital like this can make it. We have looked at this from a serious standpoint, in terms of reviewing past performance of lots of healthcare systems, and we see that because of the approach here not having overhead that necessitates a high price tag associated with it, that a hospital like this can make it. The major listing has already been done. Trinity should be given coodles for that. However, we think that what we can bring to what already happens at this location adds to it. If you go back to the February 26th meeting, the statements that were made that was at the facility was only 65 percent occupied, we know that there has been some discussions and some changes along those lines what people have said, but at the same time we have had the discussions as Steven said, and we have made more than the contacts, and these contacts are not new. This is basically one big discussion that has been going on for at least two and a half years at this point. The information that you received today will help document some of that for you simply because we would be spinning in the wind if this space was not available. Lastly, healthcare continues to

change. We cannot be caught up in a time warp in terms of what we do to satisfy the needs of patients in a reasonable manner. Not in a manner that would be unacceptable cost wise included. But we have to change it also. When I graduated from the University of Michigan, what they were teaching then is light years from what they're teaching now. It stands to reason that if we're going to make progress that we need to plain catch up in healthcare. Especially in a community like this. That we, the people, who are charged and have a responsibility of not only providing care, but also enforcing and making rules and regulations as well you all, have to do the same thing. There needs to be a continuity, not only of care, but a continuity of administration also. Personally I think that that can happen. I think it's a matter of getting to the point of having a proper discussion with those who are involved and committed rolling up their sleeves, and I think that it's these kinds of issues that can be translated to other parts of the state including the rural areas. I think it's something that not only of this Commission and the department that could be proud of, but also the citizens of the state of Michigan. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions?

COMMISSIONER HAGENOW: Yes. Differentiate for me why you think it's for acute care and not for primary care?

DR. JOE: If we were talking 15 years ago, Commissioner, that would be an excellent statement, simply because of what's where and where it is now. Physicians hit the wall of having primary care clinics with a certain number of patients that have certain types of diseases. We can give you a list of DRG's that will blow a primary care clinic out of the water in terms of being able to progress to the next level. We see this on an outpatient basis all the time. The clinic there has that problem. You know why, because it's a clinic taking care of primary care issues. Unless they have some magic, they are just like everybody else in this community that provides care to people. To do primary care clinics in Detroit would only service half of the issue and the serious problems will continue and they resurface in various forms and be before you at a later date. The continuity of care has to be hand and hand with not only the outpatient primary care clinics, which we all know are at a lower cost, but also the ability to avail oneself of technology. Which is what this industry has thrived on to make this healthcare system what it is. You can't have a Cat scan in every clinic. You need availability to those types of services. You need those services not just in a timely manner, but you also have to have them in a proper location. Here again, for all the diseases on the west side, we should be using the Antibiotics on the west side and not saving the ones on the east side.

COMMISSIONER HAGENOW: So, what you're saying is that there's data that would say that the primary care doctor is there now can justify the numbers of patients they are seeing? That it would justify a certain amount of access to acute care beds?

DR. JOE: It's part of the reason we have an overload in the city right now, because those numbers are clear.

COMMISSIONER HAGENOW: That may be something to look at in terms of standard of the number of primary care physicians that are seeing X amount of patients and with certain amounts, at that point, they need to have access to acute care beds that are part of their system.

DR. JOE: Absolutely. As a matter of fact, the numbers are over the top right now. That can be gleamed from the emergency room utilization all the way back to the physician's offices, the time that the offices are open, et cetera, et cetera. There is a madness to this. Believe me there's a connectivity to it also that helps clarify. It gives you a better view of what's going on when you look at it in that regard, in terms of access.

CHAIRPERSON TURNER-BAILEY: Are there any other questions? Yes, Mr. Styka.

MR. STYKA: To answer your question earlier about the Advisory Committee that are under section 22215, which is your main section through your duties, to come up with a new standard, and you can do it yourself obviously, which is probably not very practical with the other members of the Commission. The department can submit proposals to you, which is what I think Mr. Christensen has in mind here. You can appoint an Advisory Committee and give it either six months or less. In other words, you could actually in a creation of an Advisory

Committee, give them two months, three months, whatever you think is reasonable. Any period shorter than six months. And lastly, of course, you can go through the department to hire private consultants in a private organization to do the work that you need done. But I wanted to make it clear that the Advisory Committee don't automatically mean six months. You can give them a shorter period of time. Also you have the methodology that's available to you in the office.

CHAIRPERSON TURNER-BAILEY: That's useful, thank you. Any other questions for Dr. Joe?

COMMISSIONER HAGENOW: I only have one more comment. It's really impressive to see doctors and community together and say we need to do this. I think that's just very impressive. It does make me think that in many times in our way of living in the world, that it becomes a business separate from the actual partnership between physicians and community, and that is notable.

DR. JOE: Thank you for that comment. It's probably not well known in the public's eye, but physicians have always been charged with being the only ones responsible for looking patients in the eyes and meeting their needs. At the same time, we've been the only ones charged in leading beyond the bottom line. Everybody is so stuck on what's proper on the bottom line. Physicians possess a unique ability in a one-on-one situation most of the times it can be expanded to broader ranges to actually lead beyond the bottom line. We're beginning to see that happen in healthcare in lots of unique ways.

CHAIRPERSON TURNER-BAILEY: Thank you. Barbara Jackson.

MS. JACKSON: Hi again, Barbara Jackson, Economic Alliance. In Larry's absence, and I know you're all sad he's not with us, but I will be very brief. I just have a few tidbits. This is in terms of Economic Alliance for Michigan's comments on this issue. There is no current CON defined needs for additional hospitals anywhere in this state according to either the existing CON bed need number for each hospital sub area, or the new bed need numbers developed according to the updated and liberalized needs standards that were finalized. Regarding the CON process, over the years we have supported the Commission considering modified need standards when appropriate for various categories for CON covered health facilities or services to determine if certain situations merit differential treatments. However, on the substantive CON policy issue, the Economic Alliance concluded that the case is not yet been made for differential CON standards for any proposed new or re-opened hospital anywhere in this state, including the Unity Health proposal. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Any questions? Thank you. That ends the public comment on this issue, so a motion will be in order. Commissioner Ajluni.

COMMISSIONER AJLUNI: Yes. Motion on the table. Support.

CHAIRPERSON TURNER-BAILEY: We move for support that we table the Unity Health issue until the June meeting?

COMMISSIONER AJLUNI: Yes.

CHAIRPERSON TURNER-BAILEY: Any discussion? All those in favor, signify by raising your right hand. Ten, opposed. Motion carries. We're going to break for lunch now and resume at 1:00. Thank you.

(Whereupon a lunch break was taken) (Back on the record at 1:00)

CHAIRPERSON TURNER-BAILEY: The next item on the agenda is the status of the CON Commission bylaws. Brenda.

BRENDA ROGERS: Again, this is Brenda Rogers. The reason that we put this on the agenda is to let the Commission know that we are internally within the department taking a look at the Commission's bylaws, trying to go through making any suggested changes. We will be bringing that back to the Commission. I'm not sure exactly on what date, but I wanted to let you know, and Ron is also involved in that, so we are taking a look at

that, and we will be bringing it to the Commission at some point. So, if any Commissioners, in the meantime, you have some suggestions or changes, feel free to let us know or at the time that you do receive the language, and you'll also have an opportunity to go through it, but we at least thought that we would get a start on this process.

CHAIRPERSON TURNER-BAILEY: Thank you. We had a couple of Commissioners that I thought who volunteered to work on that. Does anybody remember volunteering to work on the bylaws?

BRENDA ROGERS: If someone is interested, I mean, we can share-----but if anybody is interested in helping us out, let me know and we will share what we started working on.

CHAIRPERSON TURNER-BAILEY: Commissioner Goldman has generously volunteered his time. Thank you very much. Okay. Selection of hospital beds and the Advisory Committee: We have from the department a list of all the potential members of the Standard Advisory Committee and we agreed at the last meeting to set up. I think the department suggested and the Commission agreed that they would go through and make a recommendation as to who would handle this matter. We would agree or not at this meeting. I do want to tell you that I have received a copy of a letter, a nominating letter that it's unclear what happened to it when the original letters that were going through, but the letter is dated prior to the deadline. This was nominating James Ball to be a member of that Committee. I would like to add his name to the list. We're not clear as to what happened, but we do know that cyber space does sometimes eat things up. I think we've all had that happened.

LARRY HORVATH: Since you've added him to the list, can you tell us what category you added him for?

CHAIRPERSON TURNER-BAILEY: Purchaser. Also, there was an alternate, Janice Whitehouse from General Motors. So, the way the list is laid out, and Brenda maybe you can just give an explanation of how the department pulled these together and what code means that we have here.

BRENDA ROGERS: What you have in front of you is the complete list of all the nominations that we received. On there is in order by category first, so consumer experts, paying providers and purchasers. You will notice on a few of them they might say experts/provider, or provider/expert. The reason for that is that they could be either of those categories. The other way this is organized, within each of those groups if an alternate was submitted with a nomination, then the alternate is listed before the regular member. What we did at the department was that we put together a potential list and those names are in bold on this full list. I think that's it, unless you have some new questions.

CHAIRPERSON TURNER-BAILEY: Commissioner Sandler.

COMMISSIONER SANDLER: I was wondering not about Mr. Ball's qualifications but by there has to be a two-third majority of experts. Mr. Ball is being added to the Committee. Who is being subtracted from the Committee? That's my question.

CHAIRPERSON TURNER-BAILEY: That's a good question.

COMMISSIONER SANDLER: Mr. Ball is well qualified, we all know that, but you have to have this two to one ratio.

CHAIRPERSON TURNER-BAILEY: Right, we would have to have one of the purchasers withdraw from the Committee. I actually do have a letter from Joseph Sercone, and actually it's unrelated. His withdrawal statement has to do with a change in job responsibilities, so it's actually convenient that happened, and Mr. Ball's qualifications came in.

COMMISSIONER MAITLAND: I guess I am a little confused. I'll change the subject a little bit. So, the ones who aren't in bold are the alternates? You said the alternates were before -----I don't understand how that works.

BRENDA ROGERS: Let me just give you an example. If you look at the very first sheet right at the very top, the consumers. You have Todd Regis and Sandi McLloyd. Todd Regis is the alternate for Sandi McLloyd. If you go down just a little bit further, down towards the experts star, you have Mark Hutchinson and Robert Meeker, and the alternate for Robert Meeker is Mark Hutchinson. So alternate is listed right before the regular member. The way you can tell is if you look at the organization represented because those will be the same.

CHAIRPERSON TURNER-BAILEY: So, those four people are actually two nominations.

COMMISSIONER MAITLAND: Can you just tell us which ones are the alternates. Oh, alternate, why didn't you say that?

BRENDA ROGERS: I thought I did.

CHAIRPERSON TURNER-BAILEY: So, there are several that do have alternates already defined. That's something that we might want to deal with once the Committee is seated to allow these organizations and we can discuss that and there needs to be a motion to that affect to allow------I think it's important to have an alternate because for continuity purposes. If somebody can't make it to a meeting it certainly would be helpful if they could send their alternate. I guess the first set of discussions should be about the make up of those that are in bold with that.

COMMISSIONER MAITLAND: Again, if we just take the ones in bold, and then we consider the six alternates here or there and remove them, then we have the proper mix? I move that we approve this as proposed with the replacement of James Ball for Joseph Sercone.

CHAIRPERSON TURNER-BAILEY: James Ball also had an alternate, Janice Whitehouse.

COMMISSIONER MAITLAND: With his alternate, Janice Whitehouse.

CHAIRPERSON TURNER-BAILEY: It's been moved and supported that we accept the nominees for the hospital bed Standard Advisory Committee as the department has proposed with the change of accepting the withdrawal of Joseph Sercone and replacing him with James Ball, with his alternate, Janice Whitehouse. Is there any discussions? Commissioner Goldman.

COMMISSIONER GOLDMAN: It would be useful for the Commission to have just a brief explanation for why we need the Standard Advisory Committee. What I had heard from Jan earlier is that the department is looking at the Unity issue, and he was going to bring some recommendations back to us next month. I don't want to get that confused, so I would like to be very clear about the purpose for this group.

CHAIRPERSON TURNER-BAILEY: Well, certainly our discussion at the last meeting, and I'll welcome any of the other Commissioner's memory towards this as well. Was that it is appropriate for us to take a look at the access issues as it relates to need. Certainly this was coincident with the discussion on the Unity issue, but I think that there was an assumption and understanding that the Unity issue was not the only issue that would require us to think about whether or not or how access could be used as a part of the needs requirement standard.

COMMISSIONER MAITLAND: So, the notion was that this Commission would, or this Committee would look at statewide access issues?

CHAIRPERSON TURNER-BAILEY: Now, I'm answering for what I would expect, and we need to give the charge. But certainly this was not to look at one organization but to look at access.

COMMISSIONER GOLDMAN: It's not the charge. I'm just consistent with our discussion this morning, and it's consistent with the time frames that they have to do their job within a six month period and the department is indicating that they may have some proposed language for us on the Unity issue, as early as our next meeting, which is next month. I wonder if we should say something like this is a Standard Advisory Committee that would

be looking at access problems generally for the State. Looking at our current bed need methodology to see if it needs any changing or tweaking, but for them to not necessarily concentrate on a particular problem in any particular area at the present time, but rather look at mythological kind of questions. Because otherwise we could have the department working on a particular matter and the Committee working on a particular matter and working it cross purposes or using resources inappropriately.

CHAIRPERSON TURNER-BAILEY: I guess I don't see the two as being mutually exclusive at all.

RON STYKA: I think if you read the charge that you previously adopted in March, it is broad. It does cover the whole state in terms of accessibility in these issues that you've been talking about. Certainly if the department were to come forward with the proposal that's a sub part of that, you could always at that point tell the Committee that we don't need to look at that portion just like the rest of it.

CHAIRPERSON TURNER-BAILEY: Any further discussion?

LARRY HORVATH: Was Commissioner Maitland's motion seconded?

CHAIRPERSON TURNER-BAILEY: It was. Who supported it? Commissioner Goldman. Commissioner Hagenow.

COMMISSIONER HAGENOW: I want to understand how it does interface. How does this Standard Advisory Committee interface with the community department, the board, the staff?

MR. SANDLER: The money that is being saved in microphones, are going for healthcare. So, this should eliminate any concern that the money is being wasted for bureaucratic red tape.

MR. CHRISTENSEN: Actually the restriction on microphones was brought about by our physical activity people who thought that we were going to be able to stand up and move around and pass things around. At the next meeting the microphones will weigh five pounds. I think the charge originally came about; the department urged the creation of this committee because of some later concerns that we had with the bed need methodology that we adopted. It generally makes good sense. I think in many ways it's a significant improvement on the bed need methodology we had prior to the newer one. But there was still some concerns that it wasn't precise enough to look at some access issues. So, we wanted an opportunity to take another hard look at that. Along with that, 619 has a sub section in it. Which requires the Commission actually to take a look at transferring hospital beds to non-facilities. In terms of movement and access and need. So, this Standard Committee can fulfill that responsibility that you have under 619 by making recommendations related to access to care. We would like to bifurcate the issue of Unity. Look at Unity as a unique circumstance. A case that they make for the particular community their in, but allow this Standard Committee to move towards considering generally the need for access and what adjustments need to be made, if any, to the bed need methodology, or additional access standards that might ride above the bed need methodology for the state of Michigan. There is in our view something missing in the overall bed need methodology with respect to access to care. We'll find out. We'll find out, we'll see what this distinguished committee that we have here will be able to give us after six months.

COMMISSIONER HAGENOW: I was looking at the question of how that interrelates. It's not possible as Mr. Goldman said, or Dr. Goldman, which ever he is. Commissioner Goldman said that there's cross-purposes going on. That isn't going to happen because you're going to staff the SAC, right?

COMMISSIONER GOLDMAN: We'll be involved in both groups, and I don't see it as being conflicting. I think the resolution of the Unity issue happens only when all of the parties, all of the major players in healthcare come to an agreement that will allow something to happen that doesn't violate the basic intent of the bed need methodology and doesn't increase the number of active licensed beds in Detroit. What that is exactly is something that we'll work on intensely within the next month or so. I think it's a slightly different issue then looking at a general standard issue that apply for many of the urban areas of the state.

CHAIRPERSON TURNER-BAILEY: It's my opinion that the Committee might want to keep a Unity like issue in mind. When it's liberating in discussing this issue, but certainly don't have to be caught in just dealing with Unity, relative to looking at access issues.

COMMISSIONER MAITLAND: This is Maitland. I agree with the Chairperson. I think that access has come up several times and it is important. It is in the charge phase now, and I think the answer with this Ad Hoc Committee will help us in making a decision on Unity whether it's addressed specifically or not.

CHAIRPERSON TURNER-BAILEY: Is there any further discussion? Okay, well, it's time to take a vote on the motion on the table. All of those in favor please signify by raising your right hand. Opposed. Unanimous. We should write this down.

BRENDA ROGERS: This is just a follow up. Your current bylaws state that the Commission Chairperson shall select a chairperson of the Standard Advisory Committee, so I'm not sure how you want to handle that, but that does need to be done as well. Also we do have a tentative meeting date for the Standard Advisory Committee May 25th. I believe that is in the Lake Ontario room at the Library, so we will put notices out. This will be an open meeting.

CHAIRPERSON TURNER-BAILEY: I want to ask you about two things. The issue of the Chair, and also the issue of the ability to select an alternate. Do we need to make some sort of motion or decision on that as well, or can we just say the people can establish an alternate?

BRENDA ROGERS: In the past we've always allowed for submission of alternates to be submitted once the Committee has been selected. Also in the past though, the Commission voted to let the Chairperson handle that. So, you might want to make a motion to that effect. Again, and as to the Chairperson of this Committee, you'll have to make that decision whether you'll be doing that today of after today's meeting. We just need to know who that Chairperson is going to be.

COMMISSIONER MAITLAND: I would move that we allow the Chair, with review of the department on the qualifications, add alternates to any of those members who don't have an alternate at this time.

BRENDA ROGERS: Could you add to that too, Jim, if a regular member needs to drop off for whatever reason, that if we need to add somebody else, do you want to give that permission to the Commission? That's up to you.

COMMISSIONER MAITLAND: You're giving me an awful lot of power, but I'll take a chance on it.

CHAIRPERSON TURNER-BAILEY: And the support for the amended motion?

COMMISSIONER GOLDMAN: Support.

CHAIRPERSON TURNER-BAILEY: Any discussions?

COMMISSIONER SANDLER: Do you wish to take a nomination for Chair at this time? Do you want to just clean this up?

CHAIRPERSON TURNER-BAILEY: Can we vote on this motion? All in favor, raise your right hand. Opposed. Unanimous.

COMMISSIONER MAITLAND: Dr. Sandler is going to make a comment, but I think we should just follow the bylaws and allow the Chair to appoint the Chairperson. That's what we've done for a long time. If someone has a recommendation, they should just let the Chair know.

COMMISSIONER SANDLER: I didn't have anyone in mind.

CHAIRPERSON TURNER-BAILEY: I'll do that very shortly before May 25th. Any other outstanding issues on the Standard Advisory Committee? Brenda, anything else we need to take care of?

BRENDA ROGERS: No.

CHAIRPERSON TURNER-BAILEY: Thank you. That was our first time doing that. I thought that went very well. New Medical Technology.

BRENDA ROGERS: Nothing new to report.

CHAIRPERSON TURNER-BAILEY: Compliance Report.

BRENDA ROGERS: No report.

CHAIRPERSON TURNER-BAILEY: Legislative Report.

BRENDA ROGERS: Nothing there either.

CHAIRPERSON TURNER-BAILEY: Work Plan. Mr. Marquardt, did you want to speak on the Work Plan?

MR. MARQUARDT: No, not right now.

CHAIRPERSON TURNER-BAILEY: We'll get to you then. I've been holding your card. We'll get to it when we get to public comment. Brenda, do you have anything?

BRENDA ROGERS: Okay. Going through the Work Plan. Hospital beds will remain on the Work Plan and again as I mentioned earlier, there is a tentative meeting date for the New Standard Advisory Committee on May 25th. We will have a possible proposal regarding Unity Health at the general meeting. The MRI will be removed from the Work Plan due to final action on that today, was submitted to the Legislative Committee on the Governor for the 45-day review period. Megavoltage Radiation Therapy will remain on the Work Plan. Nursing Homes and Hospital Long-Term Care Unit remains on the Work Plan. Again, we'll have a proposal for you at the June meeting. Positron Admission Tomography Scanner Services remains on the Work Plan. Surgical Services remain on the Work Plan, and Commissioner Hagenow will be giving a brief update here shortly. New Medical Technology remains on 2002, page 16, 19 sections remain there as we continue to work through those issues. We would like to add the possibility of the submission of the CON annual report for fiscal year 2003, we hope to have that for the June meeting.

CHAIRPERSON TURNER-BAILEY: Any questions?

COMMISSIONER HAGENOW: I can give a comment. As liaison for the Surgical Services Standard, I had a meeting with the department who understands exactly what it meant to be a liaison. We set up a time line. We're in the fact finding right now with the different constituents that we believe have an impact and would like to be telling us what we need to understand about the present standards and how they should change definitions and so on. And then come forward with the proposed new language by the September meeting, and then of course we'll go through the broader public hearing in the former advisory if needed or not. Depending on the significance of the changes and the constituents that are involved. We're looking for a timely conclusion at the end of the year, in the December meeting.

CHAIRPERSON TURNER-BAILEY: Thank you. Do we have any comments? Commissioner Sandler.

COMMISSIONER SANDLER: Not about the Surgical. This is about the test standards. I think this is the appropriate time to bring it up. At the last meeting there was a comment made by Mr. Dovers from Flint about some tactical issues related to the test standards and who was going to meet with the department. It wasn't necessarily an advisory committee. Has this taken place or has it not taken place. He's dropped the ball or he just didn't get together or we don't know? Well, the content couldn't be that important. Thank you for the follow

up.

CHAIRPERSON TURNER-BAILEY: Robert Marquardt.

MR. ROBERT MARQUARDT: Good afternoon. My name is Bob Marquardt, and I'm the president and CEO of Memorial Medical Center in Ludington, Michigan. I'm here to address the issue of Radiation Therapy. I was interested in this morning's comment because they really addressed two issues. One, was the issue of access to care, and the other one was the issue of timeliness of standard development. I kind of think of those as sort of need and speed. I've been working in my own facility on Radiation Therapy development since 1991. Most recently I presented public testimony to the department. At its July meeting. I addressed this Commission in September and have been expecting the issue of draft standards to come forward to this Commission since that time. In two months, it will be a year since I presented public testimony. I am frustrated. I would like to see draft standards come forward and I would to see the issue addressed. The issues in my service area are very real. I will admit that my whole service area is only 71,000 people. It's probably less than the community that was represented this morning. But the issues of population size are not the issues here; the issues are access of care. The people in my region must travel more than one hour one way. That's a strain on them. That is too long. I am requesting standards to shorten that distance, if you will. That's the need. The statistics, I guess bear it out. We have Cancer rates that are higher than the state average. We have morbidity and mortality rates in Cancer that are above the state average. Those folks aren't going away. Frankly what's happening is that they are not accessed to care. The need is there. I'm simply requesting that the Commission and the department keep attempting to keep this issue on your agenda for June, if you would. I know it's a difficulty for the department, because I know they have to balance a number of issues. I appreciate that. I think that we have demonstrated our patience on this. It's a small issue. It affects a small number of people. It affects a small number of hospitals. There is an attachment or a piece of the MRT standards that do affect a larger population for intensity modulated Radiation Therapy, or MRT. Those standards as well need to be addressed for the general population. So, this is not only a small hospital in a small rural area issue, it does affect the rest of the state. I would request that if you will, that you will attempt to get this issue on your agenda and keep it there so that we can look forward to taking care of our population. I'll be glad to answer any of your questions?

CHAIRPERSON TURNER-BAILEY: Are there any questions? Commissioner Hagenow.

COMMISSIONER HAGENOW: I don't know if this is for you or for us. Exactly what is our status at the moment?

BRENDA ROGERS: Right now it's on hold.

COMMISSIONER SANDLER: Radiation Oncology standards at one time was on the agenda, and we didn't get to it. I think that was in '03, so we temporarily dropped it because of other issues.

CHAIRPERSON TURNER-BAILEY: Thank you. Any discussion?

COMMISSIONER HAGENOW: Do we have a liaison for this? Would it be good to ask to liaison on it.

COMMISSIONER MAITLAND: I think normally the department takes the initiative in it, and it has been on hold because of priorities, I think. We did have it for July for public hearing, correct? Are you moving that back because we don't have anything or are we going to try to do something?

CHAIRPERSON TURNER-BAILEY: That was last.

COMMISSIONER MAITLAND: I think I let this slip and I will talk to the department and try to get a handle on where we're going to go on this issue.

COMMISSIONER SANDLER: Let me comment. The Radiology Oncology person from the Michigan Radiology Society, Dr. Hutchinson, did attend at some of these meetings, but it didn't get on the agenda. There has been a number of letters that we haven't got on this topic. Not on the topic of rural area radiation, but there was an up date of the standards because some of the newer Radiation Oncology procedures take a little longer, because

they're actually better because they're more focus, so there's less complication, but it'll take longer to fractionate it. With that, we'll ask that the change in the standards to accommodate this from the original letters. Just to refresh everyone's memory.

CHAIRPERSON TURNER-BAILEY: Thank you. We'll get a status report from our liaison if not at the June meeting, then very short after. Any further questions or comments? Is there a motion to accept the Work Plan as written.

COMMISSIONER GOLDMAN: I move for the motion.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Goldman.

COMMISSIONER HAGENOW: I support it.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Hagenow. Any discussion?

COMMISSIONER MAITLAND: Well, since I let it slip. Why don't we try to get something in September. Do you think we can do that. Yes, we will attempt to have something, some recommendations in September.

CHAIRPERSON TURNER-BAILEY: We'll push to get that.

COMMISSIONER SANDLER: Madam Chairperson, can I ask a question? Now that this has been brought out, I would assume Dr. Gustaston, who was playing the lead role for the Michigan Oncology Society, represents both the diagnostic Radiologist and the Radiation Oncologist. Do you want him or a representative at Michigan---- there is actually a Radiation Oncology Society. Do you want them to meet with the department? How do you want me to convey to this group that they have the opportunity for input, plus they could help address this rural issue as well. How would you like this to proceed?

COMMISSIONER MAITLAND: I'll talk to the staff and they'll remind me of what the specific issues that were brought are, which I can't exactly remember now. And then we'll put together a team and we'll discuss it. We will include them.

COMMISSIONER SANDLER: I will give to the department the appropriate contact material, and they'll be able to contact directly people, experts who have an interest in this. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are those in favor of a motion, please signify by raising your right hand. Opposed? Unanimous. Future meeting dates: Our next meeting, which is a regularly scheduled meeting, is June 15th. Our agenda says 2003, but it's actually in 2004. For the remainder of the year we're looking at September 14, 2004. With that I'll go to public comment: Barbara Jackson.

MS. JACKSON: Just a brief comment. I'm Barbara Jackson again. In view of Jan's comment about the departmental proposal regarding Unity Health that may be coming up at the June 15th meeting, I think it's really important that this proposal be made available prior to the meeting, maybe a couple of weeks. Maybe through a website. Especially in view of the executive order that says nothing can be printed for the public except for the final agenda and proposed language. I think it's important for those of us out here in the peanut gallery, to also be able to review the proposal and get some sense of it. That's all. Thank you.

CHAIRPERSON TURNER-BAILEY: Are there any further questions. Hearing not, I'll accept the motion for adjournment.

(Whereupon proceedings concluded)